MANAGED RISK MEDICAL INSURANCE BOARD
Healthy Families Program Advisory Panel Summary
Meeting of August 3, 2005
West Sacramento, California

Members Present:	**Jack Campana, William Arroyo, M.D., Ronald Diluigi, Michael Kirkpatrick, Heather Bonser-Bishop, Maria Villalpando, Ellen Beck, M.D., Steven Tremain, M.D., Elizabeth Stanley-Salazar, Iantha Thompson, Leonard Kutnik, M.D., Paul Morris, D.D.S.**
Staff Present:	**Lesley Cummings, Laura Rosenthal, Janette Lopez, Vallita Lewis, Ruth Jacob, Ernesto Sanchez, Renee Mota- Jackson, Mary Watanabe, Adriana Alcala**

Introduction

Jack Campana, Healthy Families Program (HFP) Advisory Panel Chair, opened the meeting by introducing himself and asking the Panel members, staff and the audience to introduce themselves.

William Arroyo, M.D. announced that in May, Lesley Cummings, Executive Director for the Managed Risk Medical Insurance Board (MRMIB) was honored by the California Mental Health Advocates for Children and Youth (CMHACY) for her career in the advocacy of children.

Review and Approval of the May 4, 2005 Healthy Families Program (HFP) Advisory Panel Meeting Summary

The May 4, 2005 HFP Advisory Panel Meeting Summary was approved as distributed.

Recruitment of Subscriber with Special Needs Representative

Janette Lopez, Deputy Director of Eligibility, Enrollment and Marketing for MRMIB, announced that Margaret Jacob had withdrawn from the Panel leaving the Subscriber with Special Needs seat on the Panel vacant. Ms. Lopez stated that the person filling this position would serve the remainder of the term and then the person could reapply if they wanted. She asked the Panel to encourage eligible applicants to apply by August 31, 2005.

Maria Villalpando asked if the subscriber only needed to be in HFP or if they also had to be in California Children's Services (CCS). Ms. Lopez responded that the HFP statute requires the family to have a special needs child enrolled in HFP.

Discussion on Election of a Chairperson

Laura Rosenthal, Chief Counsel for MRMIB, discussed the legal issues that effect who can be a Chairperson. She stated that there are two issues. The first is that, by law, the Chair person is also a non-voting member of the Board and therefore the individual should not be employed by or represent a health plan, clinic or provider that contracts with MRMIB. The second issue is the conflict of interest based on the Political Reform Act. Laura distributed a copy of Insurance Code 10730 and reviewed the key issues of the Political Reform Act.

Ms. Rosenthal stated that the fundamental rule is that a member of the Board is a public official and therefore can not use their position to influence a decision where they have a financial interest. They can not be a part of a discussion where the Board's action could influence a personal financial interest. Ms. Rosenthal reviewed the 8 step test for being disqualified based on economic interests. Ms. Rosenthal added that if the Board's decision could affect an entity where the person has a business position or where they are earning money, this would also disqualify them. She stated that someone could work for a provider that has a contract with one of the health plans or is impacted by MRMIB's regulations and this would disqualify them as well.

Steven Tremain, M.D. asked Ms. Rosenthal to define health care service plan. Ms. Rosenthal stated that a health care service plan is defined by the Knox-Keene Health Care Service Plan Act of 1975 and is licensed by the Department of Managed Health Care. It applies to anyone working for an insurer or health plan.

Leonard Kutnik, M.D. asked if this would disqualify someone from sitting on the Quality Improvement Work Group. Ms. Rosenthal replied that this applied to members of the Board and therefore, the Advisory Panel Chair only.

Ronald Diluigi asked how the Chair would become privy to confidential information if they were a non-voting member. Ms. Rosenthal replied that the Chair participates in the non-public sessions and while not able to vote, does participate in discussions and could influence the decision. It could mean that the Chair would have to be excused from some discussions or sessions. If the Chair were in a position where it is more than a rare event where they would have to excuse themselves, it would be awkward and the Chair would not be able to fully represent the Panel.

Dr. Kutnik stated that if you own stock in a managed care plan in California with a value of $2,000 or more, it seems like this would be a conflict of interest. Ms. Rosenthal replied that his statement was true and it is that basic.

Mr. Diluigi stated that it doesn't mean you couldn't be Chair, it just means you would have to excuse yourself. Ms. Rosenthal replied that was correct, but would also mean the Chair would have to be disqualified from so many decisions that it would be impractical.

Heather Bonser-Bishop asked that in the interest of time if Mr. Campana could talk to those that are eligible. Ms. Rosenthal stated that several Panel members had asked for an overview of the eligibility requirements because they did not know if they were eligible. Ms. Rosenthal said that she would be happy to work with individuals on specific questions and that they should contact Janette Lopez.

Mr. Campana stated that he would also like for Ms. Rosenthal to come back to discuss rules on open meetings. Ms. Rosenthal recommended that this be agendized for a future meeting.

Strategic Planning

Ellen Beck, M.D. had a conference call with Ms. Cummings and had developed a list of issues for the Board to consider. Mr. Campana and Dr. Tremain were unable to participate in the scheduled call. Ms. Cummings added that she participated as a resource. Dr. Beck stated that several meetings ago, the Panel had discussed what direction the Board should take if there were an opportunity for growth. This could be in the form of more funding, demonstration projects or a different direction. The Panel had suggested that a strategic plan would be helpful. Dr. Beck presented a proposal of priorities for future development of HFP and asked the Panel for their input.

Dr. Arroyo asked that consideration be given to prevention and intervention services and asked that primary prevention be included in the improvement of existing services.

Dr. Tremain stated that the expansion of benefits has to be reasonable and worth it for this population and has to have a meaningful fee schedule to attract providers. He added that if the orthodontia benefit is to be expanded, it should be a true benefit.

Paul Morris, D.D.S. stated that Dr. Beck did a great job. He stated that he would like to see wrap around dental coverage as part of the expansion of population covered. Many families have private health insurance but don't have dental or vision coverage. Since they have private insurance, they are ineligible from participating in HFP for dental and vision coverage.

Mr. Diluigi recommended making the application simpler and simplifying the administration process to maximize enrollment as a way to improve existing services.

Ms. Bonser-Bishop stated that improved access to dental services and quality measurement should be a priority. She added that she would like to see community health providers and traditional safety net providers receive improved reimbursement.

Dr. Beck summarized the recommendations made by the Panel and the Panel discussed what the next step should be.

Dr. Kutnik questioned the ongoing purpose of the exercise. He questioned what would be accomplished by preparing a list of things to forward to the Board. Dr. Beck replied

that if the Panel could reach a consensus, they could then look at taking the next step to making some of the items a reality. Dr. Kutnik suggested that the Panel recommend one or two priorities, as they would have more impact and significance.

Dr. Tremain stated that when there are opportunities that present themselves, the Chair should present the issues to the Board, but the list should be prioritized and refined. Mr. Campana stated that it would be good to look at what it would take to accomplish some of these things.

Iantha Thompson stated that adolescents is a good example of where society has fallen short and it would be good to offer suggestions on how improvements can be made.

Elizabeth Stanley-Salazar said the list compiled is a summary of three to four years of discussion on issues of importance by past and present Panel members. The Panel asked for a partnership with the Board to acknowledge these priorities, and the opportunity for the Panel to participate in the decision making process.

Dr. Arroyo asked if the Panel had sent a list of priorities to the Board in the past. Mr. Campana replied that the Panel has advised the Board in the past and they have been receptive. Ms. Cummings said that staff is disadvantaged by the loss of institutional knowledge and she was unsure of what has happened in the past. She added that the Panel sending a list of priorities to the Board was compatible with their advisory role.

Dr. Tremain stated that this was also a brainstorming exercise about how the Panel can be more effective in addition to serving as a strategic plan for the Panel.

Dr. Beck agreed to make changes to the list based on input from the Panel and send it to the Panel members for approval before August 31, 2005. The Panel agreed to send their comments, along with a paragraph or two on the areas that were of interest to them, to Dr. Beck by the end of September.

Ms. Cummings reminded the Panel that the first round of the mental health assessment was almost done. Ms. Stanley-Salazar stated that she would like to better understand the process and goals of the assessment. Ms. Cummings replied that it was an examination of services provided to children who are SED to determine if it is a useful benefit and to identify the barriers.

Mr. Campana thanked Dr. Beck for her work on the strategic plan.

Budget Update

Ms. Cummings stated that the 2005-06 Budget was passed and she reviewed the highlights. She noted among other things that the Board received three positions to work on the development of a HFP Buy-In program for the counties who do not have the infrastructure to establish their own program. She added that the Board would like to

have this program started by July 1, 2006, but are looking at whether or not this is a critical date.

Dr. Beck asked if county staff, MRMIB, or Maximus would administer the program. Ms. Cummings replied that MRMIB staff would design the buy-in as well as provide technical assistance to the counties interested in establishing their own program. Initially MRMIB thought Maximus would made eligibility determinations but the issue is still being discussed. Each county would have their own funding sources and it would be a challenge for Maximus to manage the different funding sources.

Ms. Cummings reviewed the changes in the Omnibus Health Trailer Bill (AB 131). Ms. Thompson asked if the Healthy Families Accelerated Enrollment Program had taken effect. Ms. Lopez stated that only children eligible for share of cost Medi-Cal in households with income up to 250% of federal income guides would be eligible for the accelerated enrollment in HFP. Ms Lopez also indicated that she is working with DHS and Maximus on the electronic system in place.

Michael Kirkpatrick asked how this would affect the application process. Ms. Lopez stated that it is not a problem for the Medi-Cal eligibility worker to make the assessment and the goal is to get the child access to services immediately.

Maria Villalpando asked how the child will access services once accelerated enrollment has been granted. Ms. Lopez replied that the Medi-Cal eligibility worker will put an aid code in the system and they will use a Medi-Cal Beneficiary Identification Card to see a Medi-Cal provider. The child will remain in the accelerated program until the family selects their plans and submits the first monthly premium. The family will have 20 days to complete this process.

Mr. Kirkpatrick asked how this would effect the payment to the provider. Ms. Lopez responded that the provider would be reimbursed under Medi-Cal but the Department of Health Services (DHS) would claim Title XXI, the State Children's Health Insurance Program (SCHIP) payment.

Dr. Arroyo stated that he was interested in learning how this would be implemented and asked if there would be test cases to ensure that it was seamless to the families. Ms. Lopez replied that everything would be tested and she would provide updates to the Panel on the progress and the process as it is developed.

Dental Issues

Ms. Cummings said that the Panel has asked to discuss several dental issues and was asked by former Panel member Santos Cortez, D.D.S. to continue this discussion. She had hoped to discuss the issues sooner, but Lorraine Brown, the former Benefits and Quality Monitoring Deputy Director for MRMIB, was out last year and Vallita Lewis recently took her place and was now prepared to discuss these issues.

Ruth Jacobs, Division Chief of Benefits and Quality Monitoring for MRMIB, presented an update on her discussions with DHS regarding limited access and the long waiting period to access California Children's Services (CCS) orthodontia services. Ms. Jacobs stated that in March, there were about 6,057 children treated, waiting to see a dentist, or waiting to be evaluated.

Dr. Arroyo asked if the problems were due to lack of providers or outreach. Ms. Jacobs replied that there is a shortage of orthodontists as well as problems with the new CCS billing process established by CCS. CCS is requiring orthodontists participating in CCS to be Denti-Cal enrolled providers.

Dr. Tremain asked if there were barriers that could be overcome. Ms. Lewis replied that CCS thought the issue was that the provider's were not receiving payment so they made changes to their billing system. Under the new system, one of the criteria is to participate in Denti-Cal and some providers no longer wanted to participate.

Dr. Beck said that severe malocclusion usually involves a disability or abnormality so only a few children qualify for the orthodontia benefit. In her experience, these are usually children with a disability and it is usually a challenge to provide orthodontia treatment to these children.

Dr. Arroyo stated that it sounds like the system isn't working and asked if there was a way to get out of the contract or Memorandum of Understanding (MOU). Ms. Cummings stated that it is not a system run by the Board, but the Board is identifying all the issues and possible solutions.

Dr. Kutnik stated that the changes made to the CCS system, called Enhancement 47, have caused more problems, not less. In his experience, payments are taking five to seven months. Ms. Cummings stated that MRMIB will provide an update at the next meeting.

Ms. Thompson asked if it was a systemic problem. Ms. Cummings replied that it is, but it is worse in rural areas. Ms. Lewis added that some children are waiting over 18 months for an assessment and then have to wait even longer to access services.

Ms. Villalpando stated that she went through this with her son and the first challenge was to get the provider to refer her son to CCS. She added that the HFP manual did not have any contact information on CCS and recommended that this be added. She found out that you can self refer with documentation from the dentist.

The Panel unanimously passed a motion to strongly recommend to the Board and staff to expedite the investigation and develop a resolution for the CCS orthodontia access problem.

Mr. Kirkpatrick asked how many HFP children were approved for CCS. Ms. Jacobs responded that as of March 2005, 4,700 children were being treated, 97 were waiting to be treated and 1,200 children were waiting to be evaluated.

Ms. Lewis stated that Dr. Cortez had encouraged HFP to include the use of general anesthesia in a dental office as a covered dental benefit. Currently, local anesthetic and nitrous oxide dispensed in a dental office is a covered dental benefit in the HFP. General anesthesia is specifically excluded as a covered dental benefit, unless it is administered during covered oral surgery such as the removal of teeth. The HFP benefits are patterned after the state employees' benefit, in which, general anesthesia is covered as a health (versus a dental) benefit and must be provided in a hospital or surgical center. The health benefit covers general anesthesia in connection with dental procedures when hospitalization is necessary because of an underlying medical condition or clinical status or because of the severity of the dental procedures. This benefit is only available to HFP subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. General anesthesia may be administered in either inpatient or outpatient settings such as a surgical center. In some cases where there are a large number of dental caries as well as behavioral issues, the dental plans will coordinate with the health plans to arrange for the use of general anesthesia in a hospital or surgical center. Ms. Lewis added that there is not a consensus among the dental plans on whether or not general anesthesia provided in the dental office should be added as a covered HFP dental benefit.

Ms. Bonser-Bishop stated that the dentists should have a list of hospitals that have facilities available if they need to perform a procedure. She added that part of the problem is coordinating with the family, the dentist and the anesthesiologist and then if there is a cancellation, the provider has to find another family to come in or pay for it.

Dr. Tremain asked if there is a written protocol in place. He stated that he would feel more comfortable if there were written procedures endorsed by an anesthesiologist. Dr. Morris stated that he would look into it. Ms. Cummings stated that she is not aware of any written documentation on this issue.

Dr. Kutnik stated that he has heard that the problem is acquiring a quality site for the dental surgery. He added that the Board should also make sure that children are not going to be placed at risk in the chosen facilities. Ms. Lewis stated that the main concern is that there are not enough dentists willing to perform this procedure.

Dr. Morris said that anytime you are treating children that are two to three years of age, they have a hard time sitting still and it is difficult. One option is general anesthesia and Dr. Cortez has recommended that general anesthesia be done in a dental office by bringing in a medical or dental anesthesiologist. If HFP families were to pay for this out of pocket, it would be very costly. Ms. Cummings asked if this were a standard of

practice issue or an issue with HFP. Dr. Morris replied that it is a standard of practice issue.

Dr. Tremain stated that there are definitely safety issues and asked where conscious intravenous (IV) sedation factored into this. Dr. Morris replied that in a dental office the options are: 1) local anesthesia, 2) nitrous oxide through the nose, 3) oral conscious sedation, and 4) IV sedation. He added that a license is required to do conscious sedation and oral surgeons usually have a special license to perform IV sedation. Dr. Tremain stated that the issue was bringing a dental anesthesiologist into the dental office and billing the HFP health plan.

Dr. Kutnik stated that this is also an issue in the medical arena. He added that this would be a greater problem in rural areas and if the family doesn't show up for the appointment it still costs the plan. He stated that he sees the value but it should also be looked at from the quality perspective.

Ms. Lewis stated that the plans are concerned that the individuals performing this service are properly trained and that there are an insufficient number of providers in their network to cover this. Dr. Morris said that the cost for this procedure is between $800 and $1,200. Medi-Cal will reimburse approximately $100 so there are not many providers who are willing to do this. Dr. Kutnik added that if Medi-Cal is covering it, then it has been carefully looked at.

Gayle Mathe with the California Dental Association (CDA) stated that this is an area of concern because hospital access for dental procedures has shrunk to almost nothing. She added that the issue is around the lack of reimbursement. The CDA and the American Dental Association (ADA) have policy statements about training and safety and are looking at access issues again. She said the system is dramatically limiting. Dr. Tremain asked Ms. Mathe to send the Panel a copy of CDA's position on pediatric anesthesia.

Dr. Beck stated that she shared the concern about safety. She asked what the cost would be to HFP. Ms. Cummings responded that it would be difficult to determine because she is unsure how often this service is needed.

Dr. Beck asked Dr. Morris what he does when he has a child in this situation. Dr. Morris said that the options are to do nothing and let the disease progress, use some sort of restraint or to use oral conscious sedation with restraint. He added that many dentists prefer not to use oral conscious sedation and/or restraint.

Dr. Beck stated that there are access issues for adults using a hospital as well and asked if the hospitals that contract with HFP should be required to provide space and time for dental procedures.

Ms. Villalpando stated that there is also a problem with the dental office requesting authorization from the health plan. The dental office will tell the patient to pay for it because they don't want to ask the health plan for authorization.

Dr. Arroyo stated that requiring hospitals to do more cases may not be the solution but suggested that increased reimbursement might work.

Ms. Thompson reminded the Panel that lower income children have more cavities at a very young age than families in the public employee's system and suggested looking at prevention. Ms. Cummings added that the oral health demonstration projects are also looking at these issues. Mr. Kirkpatrick recommended that the Board also look at the best practices that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has for this type of procedure.

Paula Lopez with SafeGuard Dental and Vision Plan stated that she has encountered problems where a child needs a procedure but can't sit still. When trying to coordinate with the hospital and the health plan, this is seen as a behavioral issue not a medical issue. Ms. Cummings asked Ms. Lopez what she sees in commercial plans. Ms. Lopez stated that in commercial plans, this is not a covered benefit and is usually for impacted teeth or oral surgery.

Dr. Tremain recommended that the Board look at safety and access issues in addition to the billing issues. He recommended getting information from JCAHO and CDA to provide specific guidelines regarding safety issues.

Mr. Campana asked Dr. Morris what information he would be able to provide to the Panel. Dr. Morris recommended talking to a general anesthesiologist and to contact the dental anesthesiology association.

Ms. Cummings stated that it sounds like this is an industry wide issue and not isolated to HFP. Dr. Tremain stated that those that are most likely to need general anesthesia are also more likely to be the ones who are unable to pay out of pocket.

Ms. Salazar asked whether HFP could have a benefit that is different from the state employee package. Ms. Cummings replied that it was. Ms. Salazar asked staff to find out what it would take to make general anesthesia a benefit in HFP different from the state employee benefit package. Specifically, what it would take to do this, the cost, how much staff time would be required, etc.

Mr. Campana asked that dental issues be added to the agenda for the next meeting once more information was obtained from CDA.

Legislative Update

Ms. Cummings briefly reviewed the State Legislative Status Report. She recommended that the Panel look at the Chan and Escutia bills that would provide universal coverage for all children.

2004 California Children's Services (CCS) Status Report

Ms. Lewis reviewed the 2004 California Children's Services (CCS) Status Report.

Due to lack of time, the Panel did not review the Administrative Vendor Update or the Enrollment, Disenrollment and Single Point of Entry Reports.